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CRISIS OF CARE

These 7 Star investigations exposed horrific problems — and much-needed solutions — in long-term care. Here's what happened afterward

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Star journalists have been covering the crisis in nursing homes for more than two decades. Today we are revisiting seven of the most harrowing, most telling and most compelling investigations with the hope that, as [Star editor in chief Irene Gentle explains](#), we won't spend the next two decades covering the same issues.

Natalie Babineau's Story | December 2003

As Martina Chettle watched the bandage get peeled from her 93-year-old mother's lower back, she discovered the stench filling the nursing home room was the decaying body of the woman who lovingly raised her.

For more than two weeks Chettle had been asking staff about the ghastly smell coming from her mother, Natalie Babineau, and was told over and over not to worry about it, that staff would look into it.

Eventually doctors at a nearby hospital determined a bedsore had turned into gangrene. A social worker called the police.

Finding this story was not simple. The reporting started when Star journalist Moira Welsh wondered whether the province's nursing homes were prepared for the aging boomer generation. To get an authoritative look at the entire sector, the Star, using freedom of information legislation, obtained five years of complaints filed by families and staff as well as serious occurrence reports.

Buried in one of these incident reports was a line that offered no names and only scant detail but that allowed Welsh to triangulate and eventually find Babineau's family.

The ensuing story set off a wave of outrage about the care residents of long-term-care homes were receiving in the province.

Read all three parts of Natalie's story:

[For weeks there was a terrible smell coming from her mother's nursing home bed. When staff finally revealed the reason, she was horrified](#)

['I'm so sorry, I hurt your mother.' Broken leg the beginning of irreversible decline for Natalie](#)

[After repeated demands to see mother's bedsore, Natalie's family horrified to find gangrenous, cantaloupe-sized hole on her back](#)

What happened afterward:

Days after the story was published, George Smitherman, only months into his new job as Ontario's health minister, shed tears over what he read.

"I remember it like it was yesterday," Smitherman told the Star this year. "I remember the shock and horror."

At the time, Smitherman vowed to lead a revolution in long-term care.

Under his watch, the government created a complaints hotline, instituted surprise inspections and required a registered nurse be on-site 24 hours a day. He also hired 4,900 new front-line staff and set aside funding for 1,200 new registered practical nurses.

But by the end of his tenure, problems persisted in Ontario's 600 long-term care facilities.

Smitherman told the Star this year that he learned "a thousand increments does not a revolution make," adding he regrets promising he would lead a revolution in long-term-care.

"I tried very hard and did many things," he said. "(But) as part of the collective of the system, I can't be too satisfied with the outcome, can I?"

Sylvia Bailey's story | July 2011

No nursing home is perfect.

That is what Upper Canada Lodge care home in Niagara-on-the Lake told Alison Hegarty after her mother died of sepsis stemming from an untreated broken leg.

Her mother Sylvia Bailey had screamed in agony for 24 days and Hegarty worried she had injured herself falling out of her wheelchair.

Despite Hegarty's pleas to staff to have her mom's discoloured leg X-rayed, the home instead gave Bailey Tylenol and put heat gel on her knee to deal with the pain.

The heart-wrenching story came eight years after a Toronto Star series exposing neglect in long-term care led to the promise of a "revolution" by then Health Minister George Smitherman.

Part of that promise was the passing of the Long Term Care Act in 2007. It took three separate nursing home acts — individually covering charitable homes, homes for the aged and nursing homes — and combined them into new legislation. It required every home have a resident and family council; limited the use of restraints; established a zero-tolerance for abuse and neglect; and strengthened the requirement that every resident have a plan of care.

But by the end of Smitherman's tenure, problems persisted.

The revolution had not yet arrived.

Read the full story: [Nursing home gave Tylenol to resident with broken leg](#)

What happened afterward:

Alison Hegarty said she still feels shaken when talking about her mother's suffering.

"It will never, ever leave me," Hegarty said, tearing up over the phone Jan. 26.

What happened after the story published only extended Hegarty's anguish, she said.

She filed a complaint to the College of Nurses of Ontario about the care her mother received.

With the college she engaged in what is known as an alternative dispute resolution. This led to an agreement calling for the director of care at the home to engage in "practice reflection" and to review the college's professional standards, among other things.

The resolution agreement sent to Hegarty included a confidentiality clause. Offended, Hegarty signed but said she never returned the document. She also does not know if the resolution was ever carried out.

The college told the Star this year that while it does not comment on individual cases, such agreements cannot be carried out without everyone involved agreeing to them.

All of the government's reforms to improve long-term care in Ontario did little to protect Bailey or, as the Star would uncover over the coming months, many more vulnerable seniors living in the province's nursing homes.

The health and long-term-care minister at the time of this article, Deb Matthews, was unavailable to comment on this look back at what happened to Bailey.

Danae Chambers's story | November 2011

A helpless nursing home resident with advanced dementia was sexually assaulted by a nurse. Other seniors were beaten, sometimes by fellow residents, sometimes by the staff paid to care for them.

Each month, more than 10 residents of Ontario's long-term care homes were punched, pushed, verbally abused or sexually assaulted.

Abuse in long-term care, as the Star would find as part of a months-long investigation, remained under-reported. A culture of secrecy prevailed. Eight years after the Star told Natalie Babineau's horrific story, spurring a swift promise from the government of a revolution in nursing home care, the same problems existed.

This time, it was a new face and tragedy on the Star's front page: Danae Chambers, a skilled artist who painted portraits of Canada's political elite. Dementia robbed her of the ability to speak or stand. She was totally reliant on the nursing home staff — including the man who sexually abused her.

Though the Star does not usually identify the victims of sexual assault, Chambers' brother and close friend said they wanted her name included to draw attention to the dangers vulnerable women face in nursing homes.

"It was shocking, improper, and it should be stopped," her brother said.

Read the full story: [Abuse, rape uncovered in Ontario nursing homes](#)

What happened afterward:

Deb Matthews, health minister at the time, was appalled by what this investigation revealed.

She met with 10 nursing home leaders in the province and [struck a task force](#) to study the problems.

Matthews urged staff and family members of homes to report every incident of neglect or abuse to the ministry's complaint line.

Months later, after receiving 2,000 recommendations from families, staff and management of nursing homes, the task force recommended broad-reaching changes to fix the system.

The 18 "action points" to prevent abuse and neglect included separate homes for patients with dementia prone to abusive behaviour and better training for staff to handle residents with behavioural issues.

At the time, the chair of the task force said, "A lot of homes do not have enough staff, enough trained staff or the physical location for residents with behavioural problems."

Staffing shortages would persist and, as the Star would go on to uncover, Ontario nursing homes were turning to risky drugs to calm or "restrain" many of these residents.

Matthews was unavailable to comment on this look back at this Star investigation.

Ethel Geraldine Anderson's story | April 2014

Ontario nursing homes were flowing with antipsychotics.

The amount angered Donna Cansfield. She was a Liberal MPP at the time. She had spent months working back channels at Queen's Park to obtain the data, which she then shared with the Star after raising the issue with Premier Kathleen Wynne and Health Minister Deb Matthews.

The medications carry a warning that they can kill elderly patients suffering from dementia. Yet at 40 long-term care homes in Ontario, more than half the residents were on these drugs.

The drugs were often prescribed to people with aggression and other "behavioural symptoms" to try to calm them down.

The Star investigation introduced readers to Ethel Geraldine Anderson. She died after having been given an antipsychotic intended to treat schizophrenia and bipolar disorder. Anderson did not have either condition.

One of the sad realities exposed with this story is that understaffed homes used these powerful drugs too often as chemical restraints. "They tried to quiet her down," one of Anderson's nieces told the Star in 2014.

"They did the wrong thing, and it did quiet her down."

Read the stories:

[Use of antipsychotics soaring at Ontario nursing homes](#)

[Did Zyprexa kill Aunt Gerry?](#)

What happened afterward:

Antipsychotic use in nursing homes is down.

After this Star investigation, Health Quality Ontario (HQO) began publishing for individual homes the percentage of residents with no diagnosis of psychosis who are being given antipsychotics.

The most recent province-wide prescription rate measured by HQO found 19 per cent of residents without psychosis were prescribed these drugs, a major drop from 35 per cent in 2010/2011.

At Queen's Park, however, officials were not receptive to the articles.

Then-Health Minister Deb Matthews criticized doctors for overprescribing and the Star for publishing the data showing each home's prescribing rates, which she said was "raw" and "misleading."

Matthews was unavailable to comment on this look back at the government's response to the Star's investigation.

Dr. Dallas Seitz, a geriatric psychiatry expert who was interviewed for the Star's 2014 story, says it's good that rates have fallen.

But he still has concerns. A reduction in these prescriptions could be masking a move to prescribe antidepressants and other medications, he said. He also fears the isolation brought on by the pandemic could exacerbate residents' behavioural issues and reverse the progress made on reducing antipsychotic use in long-term care.

The Fix | June 2018

It was a radical idea, and, as one expert put it, the most "dangerous" to the status quo:

What if outcomes at long-term care homes improved not with a greater level of standardization in medical reporting metrics, but with a paradigm shift that puts treating residents like they are truly at home at the centre of every decision.

So the Star did something unusual: After years of stories exposing wrongdoing and failures, we spent a similarly large amount of time and resources reporting on something that appeared to work.

Peel Region's pilot project launched an entirely different conversation about long-term care in Ontario. Reporter Moira Welsh and videographer Randy Risling followed the year-long transformation of Malton Village's Redstone Unit in Mississauga into Ontario's first "Butterfly" home.

The pilot project promised to treat people with dementia with dignity and warmth, and give families a second chance at connecting with a loved one who had been all but lost to dementia.

We called the project "The Fix."

Read the full story: [One Peel nursing home took a gamble on fun, life and love. It changed everything](#)

What happened afterward:

After this series ran, an inspired City of Toronto council voted to transform homes using a made-in-Toronto version of relationship-focused care. It started in 2020 with a pilot project in one home, Lakeshore Lodge, with the hope of spreading to others.

But Ontario was still a long way from making emotion-centred care a standard in nursing homes.

Dr. Helena Jaczek was minister at the time this story was published, though two weeks later she was replaced after the provincial election brought in Doug Ford's government and his health minister, Christine Elliott.

The story, though, has stayed with Jaczek.

"As the boomers are aging, let us look at our future. Do we want to be more or less incarcerated in a massive institution where you have to eat your breakfast by 8:00?" she told the Star recently.

Jaczek, now a federal MP, said she's "haranguing anyone who will listen," including the federal health minister, to ensure any changes to long-term care prompted by COVID-19 help accomplish what the Butterfly Project set out to do: Turn nursing homes from institutions into loving homes.

Phillip Kennedy's story | December 2018

In the middle of the day, in a licensed Ontario long-term care facility busy with nurses and personal support workers, 81-year-old resident Phillip Kennedy suffered a gruesome, deep leg wound.

Nobody from Hawthorne Place Care Centre could, or would, say how it happened.

Kennedy, a loved husband and father, had been at Hawthorne only three days. The Star investigated.

For years, festering problems in Ontario nursing homes had been exposed and decried, followed by promises to act and, in some cases, even change.

Yet when the Kennedy family needed accountability for what happened to Phillip in the place entrusted to care for him, there was little.

The government investigation into Kennedy's injury did not conclusively say what caused the gruesome gash.

After an inspector interviewed at least eight employees, there were firings and a finding of "abuse and neglect" but no answers.

Read the full story: [An 81-year-old, his gruesome wound, and no explanation from caregivers: The story of Phillip Kennedy's three days in a Toronto nursing home](#)

What happened afterward:

After Phillip Kennedy's injury, the government inspected Hawthorne Place. But while Kennedy's daughter Kathleen understood this was the Long Term Care Homes Act in action, she wondered why it seemed to do so little for her family.

Hawthorne Place, like all other nursing homes in Ontario, undergoes inspections and must follow numerous regulations.

Since Kennedy's incident was detailed in the Star in December 2018, inspections continued to find issues at Hawthorne.

Then COVID hit.

In April, a nurses' association court filing alleged management at Hawthorne and two other homes failed to protect vulnerable residents and staff from COVID.

Then the military stepped in to help shore up the home's defences. By the time the deployment ended in June, 48 residents at the 269-bed home had died.

Christine Elliott was minister of health and long-term care when this article came out. She did not respond to requests for comment, but referred the Star to Merrilee Fullerton, who became minister of long-term care when the Ford government split the health and long-term care portfolios in 2019.

In a statement, Fullerton said the province has learned from its experiences in long-term care in the pandemic's first wave. She said the province is now on track to "stabilize" the sector.

The COVID-19 crisis | May 2020

We're all now familiar with the headlines.

Elderly people deprived of contact with their loved ones.

A promised "iron ring" around seniors that turned out to be more like cheesecloth.

Thousands of deaths in long-term care homes across Ontario and the country — the vast majority of all COVID-19 deaths in Canada.

Yes, when it barrelled through nursing homes, COVID-19 seemed uniquely threatening to older people with other health complications, especially those living in long-term care homes.

Premier Doug Ford's government said it had no playbook for how to protect vulnerable seniors.

But the general nature of the viral threat, and how to defend against it, was not unknown.

There were studies. Protocols spelled out. Promises made.

In this story from May 2020, Alyshah Hasham and Jesse McLean pored over decades of reports and best-practices that could have better protected seniors from the COVID-19 pandemic.

Contained within those records, repeated over years, a drumbeat of recommendations.

There was a playbook.

Read the full story: [They said there was no playbook for dealing with COVID-19 outbreak at nursing homes. There were several](#)

What happened afterward:

Despite all the warnings and battle plans, seniors in nursing homes were left exposed as the pandemic stalked Ontario.

The government launched a commission to investigate the state of long-term care homes, vowing the commission's findings would help protect residents and staff from future outbreaks.

In December, the long-term care minister, Merrilee Fullerton, [rejected a request](#) from the commission to extend its inquiry beyond its current deadline of April 2021.

The commissioners said they had encountered "significant delays" in obtaining key government records, and needed more time. Fullerton said the investigation was meant to be conducted quickly to provide officials with timely recommendations.

In a statement, Fullerton said, "We absolutely have applied lessons learned from the first wave to inform our current response." She said the province is confident the steps it's taken are "stabilizing" the long-term care sector.

Vaccinating all residents, expected to be complete by early February, is "a light at the end of (the) tunnel," she said.



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